RESPIRATORY HOMECARE SOLUTIONS

RESPIRATORY & SLEEP REQUISITION

Oxygen Therapy | Sleep Screening & Therapy

Phone: (877) 947-8686
Fax: (877) 935-4723
rhscanada.com

Patient Information

Last Name: _____
First Name: _____
Sex ☐ M ☐ F | Date of Birth (mm/dd/yy): _____
Address:
_____
Phone (Daytime): _____
Email: _____
Health Card #: _____

Patient Label

OXYGEN

Diagnosis: _____

O_2 Flow Rate:

Rest: _____ Exertion: _____
Sleep: _____ OR Keep SpO_2>: _____%

☐ ABG Results:
pH_____; $PaCO_2$_____; PaO_2_____; SaO_2_____; HCO_3_____

Funding Category

☐ Short term oxygen therapy

☐ $PaO_2 \leq 55$ mmHg or $SaO_2 \leq 88\%$

☐ PaO_2 56 – 60 mmHg (SaO_2 89-90%) in presence of:
- Cor Pulmonale, Pulmonary Hypertension or Persistent Erythrocytosis OR
- Exercise Limited Hypoxemia (exertional test) OR
- Nocturnal Hypoxemia

☐ $PaO_2 > 60$ mmHg ($SaO_2 > 90\%$) with an Independent Exercise Assessment (IEA)

☐ Palliative oxygen funding for a max of 90 days

RESPIRATORY EQUIPMENT

Diagnosis: _____

☐ Portable Aerosol Compressor
☐ Stationary Aerosol Compressor
☐ Suction Therapy
☐ Humidity Therapy
☐ CPAP
☐ BiPAP
☐ APAP
☐ ASV

DIAGNOSTICS

☐ Overnight Oximetry
☐ In Home Sleep Apnea & Snoring Screening
☐ Oxygen Assessment (ABG/IEA)

Medical Hx / Notes:
_____

☐ Snoring ☐ Hypertension ☐ Diabetes ☐ Cardiovascular Disease

Referring Physician/Practitioner Information

☐ Please confirm receipt of fax

Clinic Stamp Including Fax #

Name: _____
Signature: _____
Prac ID: _____
Date: _____
Fax Mandatory: _____
Phone: _____
Clinic: _____

☐ Please forward screening results to treating physician. (If checked please include the following information):

Name:_____ Fax: _____ Clinic: _____